STATE OF TENNESSEE
HEALTH SERVICES AND DEVELOPMENT AGENCY

500 Deaderick Street
Suite 850
Nashville, Tennessee 37243
615/741-2364

INSTRUCTIONS FOR FILING AN APPLICATION FOR A CERTIFICATE OF NEED

Please read the following instructions, the Rules and Regulations of the Agency, and Tennessee Code Annotated, §68-11-1601 *et seq.*, prior to preparation of this application.

DOCUMENTATION: In preparing this application, it is the applicant's responsibility to demonstrate through its answers that the project is necessary to provide needed health care in the area to be served, that it can be economically accomplished and maintained, and that it will contribute to the orderly development of adequate and effective health care facilities and/or services in this area. Consult Tennessee Code Annotated, §68-11-1601 *et seq.*, Health Services and Development Agency Rule 0720-4-.01, and the criteria and standards for certificate of need documents Tennessee's Health: Guidelines for Growth, and the Tennessee State Health Plan, for the criteria for consideration for approval. Both are ~~is~~ available from the Tennessee Health Services and Development Agency or from the Agency's website at www.~~tennessee~~ tn.gov/hsda. ~~Picture of the Present is a document, which provides d~~Demographic, vital, and other statistics by county and health care facility are available from the Tennessee Department of Health, Bureau of Policy, Planning, and Assessment, Division of Health Statistics and can be accessed from the Department's website at ~~www2.state.tn.us/health/statistics/HealthData/pubs_title.htm~~ http://health.state.tn.us/statistics/index.htm.

Please note that all applications must be submitted in triplicate (1 original and 2 copies) on single-sided, unbound letter size (8½ x 11 ½) paper, and not be stapled nor have holes punched. Cover letter should also be in triplicate. If not in compliance as requested, application may be returned or reviewing process delayed until corrected pages are submitted.

REVIEW CYCLES: A review cycle is no more than sixty (60) days. The review cycle begins on the first day of each month.

COMMUNICATIONS: All documents for filing an application for Certificate of Need with the Health Services and Development Agency must be received during normal business hours (8:00a.m. - 4:30p.m. Central Time) at the Agency office, located at 500 Deaderick Street, Suite 850, Nashville, TN 37243. For the purpose of filing Letters of Intent, application forms, and responses to supplemental information, the filing date is the actual date of receipt in the Agency office. These documents, as well as other required documents must be received as original, signed documents in the Agency office. Fax and e-mail transmissions **will not** be considered to be properly filed documentation. In the event that the last appropriate filing date falls on a Saturday, Sunday, or legal holiday, such filing should occur on the preceding business day. All documents are to be filed with the Agency in ***single-sided and in triplicate***.

LETTER OF INTENT: Applications shall be commenced by the filing of a Letter of Intent. The Letter of Intent must be filed with the Agency between the first day and the tenth day of the month prior to the beginning of the review cycle in which the application is to be considered. This allowable filing period is inclusive of both the first day and the tenth day of the month involved. The Letter of Intent must be filed in the form and format as set forth in the application packet.

Any Letter of Intent that fails to include all information requested in the Letter of Intent form, or is not timely filed, will be deemed void, and the applicant will be notified in writing. The Letter of Intent may be refiled but, if refiled, is subject to the same requirements as set out above.

PUBLICATION OF INTENT: Simultaneously with the filing of the Letter of Intent, the Publication of Intent should be published for one day in a newspaper of general circulation in the proposed service area of the project. The Publication of Intent must be in the form and format as set forth in the application packet. The Publication of Intent should be placed in the Legal Section in a space no smaller than four (4) column inches. Publication must occur between the first day and the tenth day of the month, inclusive.

1. A "newspaper of general circulation" means a publication regularly issued at least as frequently as once a week, having a second-class mailing privilege, includes a Legal Notice Section, being not fewer than four (4) pages, published continuously during the immediately preceding one-year period, which is published for the dissemination of news of general interest, and is circulated generally in the county in which it is published and in which notice is given.
2. In any county where a "newspaper of general circulation" does not exist, the Agency's Executive Director is authorized to determine the appropriate publication to receive any required Letter of Intent. A newspaper which is engaged in the distribution of news of interest to a particular interest group or other limited group of citizens, is not a "newspaper of general circulation."
3. In the case of an application for or by a home care organization, the Letter of Intent must be published in each county in which the agency will be licensed or in a regional newspaper which qualifies as a newspaper of general circulation in each county. In those cases where the Publication of Intent is published in more than one newspaper, the earliest date of publication shall be the date of publication for the purpose of determining simultaneous review deadlines and filing the application.

PROOF OF PUBLICATION: Documentation of publication must be filed with the application form. Please submit proof of publication with the application by attaching either the full page of the newspaper in which the notice appeared, with the ***mast and dateline intact***, or a publication affidavit from the newspaper.

SIMULTANEOUS REVIEW: Those persons desiring a simultaneous review for a Certificate of Need for which a Letter of Intent has been filed should file a Letter of Intent with the Agency and the original applicant (as well as any other applicant filing a simultaneous review), and should publish the Letter of Intent simultaneously in a newspaper of general circulation in the same county as the original applicant. The publication of the Letter of Intent by the applicant seeking simultaneous review must be published within ten (10) days after publication by the original applicant.

1. Only those applications filed in accordance with the rules of the Health Services and Development Agency, and upon consideration of the following factors as compared with the proposed project of the original applicant, may be regarded as applications filing for simultaneous review.

(A) Similarity of primary service area;
(B) Similarity of location;
(C) Similarity of facilities; and
(D) Similarity of service to be provided.

2. The Executive Director or his/her designee will determine whether applications are to be reviewed simultaneously, pursuant to Agency Rule 0720-3-.03(3).

3. If two (2) or more applications are requesting simultaneous review in accordance with the statute and rules and regulations of the Agency, and one or more of those applications is not deemed complete to enter the review cycle requested, the other applications(s) that is/are deemed complete shall enter the review cycle. The application(s) that is/are not deemed complete to enter the review cycle will not be considered ~~as competing~~ for simultaneous review with the applications(s) deemed complete and entering the review cycle.

FILING THE APPLICATION: *All applications*, including applications requesting simultaneous review, must be filed in ***triplicate*** (original and two (2) copies) with the Agency within five (5) days after publication of the Letter of Intent. ***The date of filing is the actual date of receipt at the Agency office.***

Applications should have all pages numbered.

All attachments should be attached to the back of the application, be identified by the applicable item number of the application, and placed in alpha-numeric order consistent with the application form. For example, an Option to Lease a building should be identified as Attachment A.6., and placed before Financial Statements which should be identified as Attachment C. Economic Feasibility.10. The last page of an application should be the completed affidavit.

Failure by the applicant to file an application within five (5) days after publication of the Letter of Intent shall render the Letter of Intent, and hence the application, ***void***.

FILING FEE: The amount of the initial filing fee shall be an amount equal to $2.25 per $1,000 of the estimated project cost involved, but in no case shall the fee be less than $3,000 or more than $45,000. Checks should be made payable to the Health Services and Development Agency.

FILING FEES ARE NON-REFUNDABLE and must be received by the Agency before review of the application will begin.

REVIEW OF APPLICATIONS FOR COMPLETENESS: When the application is received at the Agency office, it will be reviewed for completeness. The application must be consistent with the information given in the Letter of Intent in terms of both project scope and project cost. ***Review for completeness will not begin prior to the receipt of the filing fee.***

1. If the application is deemed complete, the Agency will acknowledge receipt and notify the applicant as to when the review cycle will begin. "Deeming complete" means that all questions in the application have been answered and all appropriate documentation has been submitted in such a manner that the Health Services and Development Agency can understand the intent and supporting factors of the application. Deeming complete shall not be construed as validating the sufficiency of the information provided for the purposes of addressing the criteria under the applicable statutes, the Rules of the Health Services and Development Agency, or the standards set forth in the State Health Plan/Guidelines for Growth.

2. If the application is incomplete, requests by Agency staff for supplemental information must be completed by the applicant within sixty (60) days of the written request. Please note that supplemental information must be submitted timely for the application to be

deemed complete prior to the beginning date of the review cycle which the applicant intends to enter, even if that time is less than the sixty (60) days which is allowed by the statute. If the requested information is submitted within sixty (60) days of the request, but not by the date specified in the staff's letter, the application is not void, but will enter the ***next*** review cycle. If an application is not deemed complete within sixty (60) days after the written notification is given by the Agency staff that the application is deemed incomplete, the application shall be deemed void. If the applicant decides to re-submit the application, the applicant shall comply with all procedures as set out by this part and a new filing fee shall accompany the refiled application.

Each supplemental question and its corresponding response shall be typed and submitted on ~~a separate~~ sheets of 8 1/2" x 11" paper, be filed in ***triplicate,*** and include a signed affidavit. When submitting replacement pages for the original application or previous supplemental responses, the replacement page should include the page number followed by a dash and the letter R(-R). All requested supplemental information must be received by the Agency to allow staff sufficient time for review before the beginning of the review cycle in order to enter that review cycle.

3. Applications for a Certificate of Need, including ~~competing~~ simultaneous review applications, will not be considered unless filed with the Agency within such time as to assure such application is deemed complete.

All supplemental information shall be submitted simultaneously ~~and only at the request of staff,~~ with the only exception being letters of support and/or opposition.

The Agency will promptly forward a copy of each complete application to the Department of Health or the Department of Mental Health ~~and Developmental Disabilities~~. The Department of Intellectual and Developmental Disabilities will review and comment on applications for Intellectual Disability Institutional Habilitation Facility (IDIHF) (ICF/IID formerly ICF/MR), however the Department of Mental Health and Substance Abuse Services will be the reviewing agency since the Department of Mental Health and Substance Abuse Services licenses IDIHFs. The Department reviewing the application may contact the applicant to request additional information regarding the application. The applicant should respond to any reasonable request for additional information promptly.

AMENDMENTS OR CHANGES IN AN APPLICATION: An application for a Certificate of Need which has been deemed complete ***CANNOT*** be amended in a substantive way by the applicant during the review cycle. Clerical errors resulting in no substantive change may be corrected.

* **WITHDRAWAL OF APPLICATIONS**: The applicant may withdraw an application at any time by providing written notification to the Agency.

* **TIMETABLE FOR CERTIFICATE OF NEED EXPIRATION**: The Certificate of Need is valid for a period not to exceed three (3) years (for hospital projects) or two (2) years (for all other projects) from the date of its issuance and after such time shall expire; *however*, the Agency may extend a Certificate of Need for a reasonable period upon application and good cause shown, accompanied by a non-refundable filing fee, as prescribed by Rules. An extension cannot be issued to any applicant unless substantial progress has been demonstrated. A Certificate of Need which has been extended shall expire at the end of the extended time period. The decision whether to grant such an extension is within the sole discretion of the Agency, and is not subject to review, reconsideration, or appeal.

* **For further information concerning the Certificate of Need process, please call the offices of the Health Services and Development Agency at 615/741-2364 or visit the website http://www.tn.gov/hsda.**

* **For information concerning the Joint Annual Reports of Hospitals, Nursing Homes, Home Care Organizations, Outpatient Diagnostic Centers or Ambulatory Surgical**

Treatment Centers, ~~call the Tennessee Department of Health, Office of Health Statistics and Research at 615/741-1954~~, visit the Tennessee Department of Health's website at http://health.state.tn.us/PublicJARs/Default.aspx

* For information concerning Guidelines for Growth and/or the Tennessee State Health Plan call the Health Services and Development Agency at 615/741-2364 or visit the website http://www.tn.gov/hsda. For information concerning ~~Picture of the Present~~ health statistics call the Department of Health, Office of Health Statistics at 615/741-9395 or visit their website http://health.state.tn.us/statistics/index.htm.

* For information concerning ~~mental health and developmental disabilities~~ mental health hospital, non-residential substitution-based treatment center for opiate addiction or intellectual disability institutional habilitation facility applications call the Tennessee Department of Mental Health ~~and Developmental Disabilities~~, ~~Office of Policy and Planning~~ at 615/532-6500.

SECTION A:

APPLICANT PROFILE

Please enter all Section A responses on ~~this~~ the form beginning on page 8 and ending at the top of page 11 and answer applicable questions on this page (page 6) on 8½" ***X 11" white paper, clearly typed and spaced, identified correctly, and in the correct sequence. In answering, please type the question and the response.*** All questions must be answered. If an item does not apply, please indicate *"N/A"*. ***Attach appropriate documentation as an Appendix at the end of the application and reference the applicable Item Number on the attachment.***

~~For Section A~~, Item 1 on page 8 please complete. *Note that Facility Name* ***must be*** *applicant facility's name and address* ***must be*** *the site of the proposed project.*

~~For Section A~~, Item 2 on page 8, please complete.

~~For Section A~~, Item 3 on page 8, please complete. *Attach a copy of the partnership agreement, or corporate charter* ***and*** certificate of corporate existence, if applicable, from the Tennessee Secretary of State.

~~For Section A,~~ Item 4 on page 8, please check the appropriate line*, Describe here the existing or proposed ownership structure of the applicant, including an ownership structure organizational chart. Explain the corporate structure and the manner in which all entities of the ownership structure relate to the applicant. As applicable, identify the members of the ownership entity and each member's percentage of ownership, for those members with 5% or more ownership interest. In addition, please document the financial interest of the applicant, and the applicant's parent company/owner in any other health care institution as defined in* Tennessee Code Annotated, §68-11-1602 *in Tennessee. At a minimum, please provide the name, address, current status of licensure/certification, and percentage of ownership for each health care institution identified.*

~~For Section A,~~ Item 5, on page 9, please complete, if applicable. *For new facilities or existing facilities without a current management agreement, attach a copy of a draft management agreement that at least includes the anticipated scope of management services to be provided, the anticipated term of the agreement, and the anticipated management fee payment methodology and schedule. For facilities with existing management agreements, attach a copy of the fully executed final contract.*

Please describe here the management entity's experience in providing management services for the type of the facility, which is the same or similar to the applicant facility. Please also describe here the ownership structure of the management entity.

~~For Section A~~, Item 6, on page 9, please check appropriate line*. For applicants or applicant's parent company/owner that currently own the building/land for the project location; attach a copy of the title/deed. For applicants or applicant's parent company/owner that currently lease the building/land for the project location, attach a copy of the fully executed lease agreement. For projects where the location of the project has not been secured, attach a fully executed document including Option to Purchase Agreement, Option to Lease Agreement, or other appropriate documentation. Option to Purchase Agreements* ***must include*** *anticipated purchase price. Lease/Option to Lease Agreements* ***must include*** *the actual/anticipated term of the agreement* ***and*** *actual/anticipated lease expense. The legal interests described herein* ***must be valid*** on the date of the Agency's consideration of the certificate of need application.

Items 7-8, on page 9, please check appropriate lines(s).

Items 9-12, on page 10, complete, if applicable.

Item 13, on page 11, if the response to this Item is yes, identify here all TennCare Managed Care Organizations/Behavioral Health Organizations (MCOs/BHOs) operating in the proposed service area. Please identify all MCOs/BHOs with which the applicant has a contract or plans to have a contract. If the applicant is planning to have a contract with a TennCare MCO/BHO, has the applicant discussed with any of the TennCare MCOs/BHOs their interest in contracting with additional providers? Discuss any out-of-network relationships in place.

1. ***Name of Facility, Agency, or Institution***

_____
Name

_____ _____
Street or Route County

_____ _____ _____
City State Zip Code

2. ***Contact Person Available for Responses to Questions***

_____ _____
Name Title

_____ _____
Company Name Email address

_____ _____ _____ _____
Street or Route City State Zip Code

_____ _____ _____
Association with Owner Phone Number Fax Number

3. ***Owner of the Facility, Agency or Institution***

_____ _____
Name Phone Number

_____ _____
Street or Route County

_____ _____ _____
City State Zip Code

4. ***Type of Ownership of Control (Check One)***

A. Sole Proprietorship _____
B. Partnership _____
C. Limited Partnership _____
D. Corporation (For Profit) _____
E. Corporation (Not-for-Profit) _____
F. Government (State of TN or Political Subdivision) _____
G. Joint Venture _____
H. Limited Liability Company _____
I. Other (Specify)_____ _____
_____

PUT ALL ATTACHMENTS AT THE BACK OF THE APPLICATION IN ORDER AND REFERENCE THE APPLICABLE ITEM NUMBER ON ALL ATTACHMENTS.

5. ***Name of Management/Operating Entity (If Applicable)***

_____
Name

_____ _____
Street or Route County

_____ _____ _____
City State Zip Code

PUT ALL ATTACHMENTS AT THE END OF THE APPLICATION IN ORDER AND REFERENCE THE APPLICABLE ITEM NUMBER ON ALL ATTACHMENTS.

6. ***Legal Interest in the Site of the Institution (Check One)***

A.	Ownership	_____	D.	Option to Lease	_____
B.	Option to Purchase	_____	E.	Other (Specify) _____	_____
C.	Lease of _____ Years	_____		_____	

PUT ALL ATTACHMENTS AT THE BACK OF THE APPLICATION IN ORDER AND REFERENCE THE APPLICABLE ITEM NUMBER ON ALL ATTACHMENTS.

7. ***Type of Institution (Check as appropriate--more than one response may apply)***

A.	Hospital (Specify)_____	_____	I.	Nursing Home	_____
B.	Ambulatory Surgical Treatment Center (ASTC), Multi-Specialty	_____	J.	Outpatient Diagnostic Center	_____
			K.	~~Recuperation Center~~	_____
C.	ASTC, Single Specialty	_____	L.	Rehabilitation Facility	_____
D.	Home Health Agency	_____	M.	Residential Hospice	_____
E.	Hospice	_____	N.	Nonresidential ~~Methadone~~ Substitution-Based Treatment Center for Opiate Addiction	_____
F.	Mental Health Hospital	_____			
G.	~~Mental Health Residential Treatment Facility~~	_____	O.	Birthing Center	_____
H.	Intellectual Disability Institutional Habilitation Facility (IDIHF) (ICF/IID formerly ICF/MR)	_____	P.	Other Outpatient Facility	_____
			Q.	Other (Specify)_____ _____	_____

8. **Purpose of Review** ***(Check) as appropriate--more than one response may apply)***

A.	New Institution	_____	G.	Change in Bed Complement	_____
B.	Replacement/Existing Facility	_____		[*Please note the type of change by underlining the appropriate response: Increase, Decrease, Designation, Distribution, Conversion, Relocation*]	
C.	Modification/Existing Facility	_____			
D.	Initiation of Health Care Service as defined in TCA § 68-11-1607(4) (Specify)_____	_____	H.	Change of Location	_____
E.	Discontinuance of OB Services	_____	I.	Other (Specify)_____	_____
F.	Acquisition of Equipment	_____		_____	

9. Bed Complement Data

Please indicate current and proposed distribution and certification of facility beds.

		Current Licensed Beds	**CON*	*Staffed Beds*	*Beds Proposed*	*TOTAL Beds at Completion*
A.	Medical					
B.	Surgical					
C.	Long-Term Care Hospital					
D.	Obstetrical					
E.	ICU/CCU					
F.	Neonatal					
G.	Pediatric					
H.	Adult Psychiatric					
I.	Geriatric Psychiatric					
J.	Child/Adolescent Psychiatric					
K.	Rehabilitation					
L.	Nursing Facility - SNF (Medicare only)					
M.	Nursing Facility - NF (Medicaid only)					
N.	Nursing Facility – SNF/NF (dually certified Medicaid/Medicare)					
O.	Nursing Facility – Licensed (non-Certified)					
P.	~~ICF/MR~~ IDIHF					
Q.	Adult Chemical Dependency					
R.	Child and Adolescent Chemical Dependency					
S.	Swing Beds					
T.	Mental Health Residential Treatment					
U.	Residential Hospice					
V.	**TOTAL**					

*CON-Beds approved but not yet in service

10. Medicare Provider Number _____

Certification Type _____

11.	**Medicaid Provider Number** _____ **Certification Type** _____
12.	**If this is a new facility, will certification be sought for Medicare and/or Medicaid?** **_____Yes** **_____No** **_____NA**
13.	***~~Identify all TennCare Managed Care Organizations/Behavioral Health Organizations (MCOs/BHOs) operating in the proposed service area.~~*** **Will this project involve the treatment of TennCare participants?____** ***~~If the response to this item is yes, please identify all MCOs/BHOs with which the applicant has contracted or plans to contract.~~*** ***~~Discuss any out-of-network relationships in place with MCOs/BHOs in the area.~~***

NOTE: ***Section B*** is intended to give the applicant an opportunity to describe the project and to discuss the need that the applicant sees for the project. ***Section C*** addresses how the project relates to the Certificate of Need criteria of Need, Economic Feasibility, and the Contribution to the Orderly Development of Health Care. **Discussions on how the application relates to the criteria should not take place in this section unless otherwise specified.**

SECTION B: PROJECT DESCRIPTION

Please answer all questions on 8 1/2" x 11" white paper, clearly typed and spaced, identified correctly and in the correct sequence. In answering, please type the question and the response. All exhibits and tables must be attached to the end of the application in correct sequence identifying the questions(s) to which they refer. If a particular question does not apply to your project, indicate "Not Applicable (NA)" after that question.

I. Provide a brief executive summary of the project not to exceed two pages. Topics to be included in the executive summary are a brief description of proposed services and equipment, ownership structure, service area, need, existing resources, project cost, funding, financial feasibility, ~~and~~ staffing, and how the project will contribute to the orderly development of adequate and effective healthcare.

II. Provide a detailed narrative of the project by addressing the following items as they relate to the proposal.

A. For the establishment or modification of a healthcare institution describe the development of and need for the proposal. Health care institutions include:

1. Nursing Home
2. Hospital
3. Ambulatory Surgical Treatment Center
4. Birthing Center
5. Mental Health Hospital

6. Intellectual Disability Institutional Habilitation Facility

7. Home Care Organization (Home Health Agency or Hospice Agency)

8. Outpatient Diagnostic Center

9. Rehabilitation Facility

10. Residential Hospice

11. Nonresidential Substitution-based Treatment Center for Opiate Addiction

Describe the construction, modification and/or renovation of the facility (exclusive of major medical equipment covered by T.C.A. § 68-11-1601 et seq.) including square footage, major operational areas, room configuration, etc. ~~Applicants with hospital projects (construction cost in excess of $5 million) and other facility projects (construction cost in excess of $2 million)~~ Applications with construction, modification and/or renovation costs should complete the Square Footage and Cost per Square Footage Chart. Utilizing the attached Chart, applicants with hospital projects should complete Parts A.-E. by identifying as applicable nursing units, ancillary areas, and support areas affected by this project. Provide the location of the unit/service within the existing facility along with current square footage, where, if any, the unit/service will relocate temporarily during construction and renovation, and then the location of the unit/service with proposed square footage. The total cost per square foot should provide a breakout between new construction and renovation cost per square foot. Other facility projects need only complete Parts B.-E. Please also discuss and justify the cost per square foot for this project.

~~If the project involves none of the above, describe the development of the proposal.~~

B. Identify the number and type of beds increased, decreased, converted, relocated, designated, and/or redistributed by this application. Describe the reasons for change in bed allocations and describe the impact the bed change will have on the existing services.

SQUARE FOOTAGE AND COST PER SQUARE FOOTAGE CHART

A. Unit / Department	Existing Location	Existing SF	Temporary Location	Proposed Final Location	Proposed Final Square Footage			Proposed Final Cost/ SF		
					Renovated	New	Total	Renovated	New	Total
B. Unit/Depart. GSF Sub-Total										
C. Mechanical/ Electrical GSF										
D. Circulation /Structure GSF										
E. Total GSF										

C. As the applicant, describe your need to provide the following health care services (if applicable to this application):

1. Adult Psychiatric Services
2. Hospital-Based Alcohol and Drug Treatment for Adolescents (exceeding 28 days)
3. ~~Birthing Center~~
4. Burn Units
5. Cardiac Catheterization Services
6. Child and Adolescent Psychiatric Services
7. Extracorporeal Lithotripsy
8. Home Health Services
9. Hospice Services
10. ~~Residential Hospice~~
11. ~~ICF/MR Services~~
12. ~~Long-term Care Services~~?
13. Magnetic Resonance Imaging (MRI)
14. ~~Mental Health Residential Treatment~~
15. Neonatal Intensive Care Unit
16. Opiate Addiction Treatment provided through a Non-Residential ~~Methadone~~ Substitution-Based Treatment Center For Opiate Addiction
17. Open Heart Surgery
18. Positron Emission Tomography
19. Radiation Therapy/Linear Accelerator
20. Rehabilitation Services
21. Swing Beds
22. Discontinuation of any obstetrical or maternity service
23. Closure of a Critical Access Hospital
24. Elimination in a critical access hospital of any service for which a certificate of need is required

D. Describe the need to change location or replace an existing facility.

E. Describe the acquisition of any item of major medical equipment (as defined by the Agency Rules and the Statute) which exceeds a cost of $2.0 million; and/or is a magnetic resonance imaging (MRI) scanner, positron emission tomography (PET) scanner, extracorporeal lithotripter and/or linear accelerator by responding to the following:

1. For ~~fixed-site~~ major medical equipment (not replacing existing equipment):

   a. Describe the new equipment, including:

      1. Brief description of equipment including characteristics such as fixed or mobile; expected vendor and model (if known); for MRI use descriptors such as Tesla strength, open/closed bore; for linear accelerators use descriptors such as MeV strength, IMRT/IGRT/SRS capability; etc.

      2. Total cost (As defined by Agency Rule 0720-9-.01(13)).

         a. By Purchase or

         b. By Lease

      3. Expected useful life;

4. List of clinical applications to be provided; and

5. Documentation of FDA approval.

6. For mobile major medical equipment list all sites that the unit is currently serving and its current schedule of operations at those sites.

b. Provide current and proposed schedules of operations.

~~2. For mobile major medical equipment:~~

~~a. List all sites that will be served;~~

~~b. Provide current and/or proposed schedule of operations;~~

~~c. Provide the lease or contract cost.~~

~~d. Provide the fair market value of the equipment; and~~

~~e. List the owner for the equipment.~~

3. Indicate applicant's legal interest in equipment (*i.e.*, purchase, lease, etc.) In the case of equipment purchase include a quote and/or proposal from an equipment vendor. In the case of an equipment lease provide a draft lease or contract that at least includes the term of the lease and the anticipated lease payments along with the fair market value of the equipment.

III. (A) Attach a copy of the plot plan of the site on an 8 1/2" x 11" sheet of white paper which **must include**:

1. Size of site (***in acres***);
2. Location of structure on the site; and
3. Location of the proposed construction.
4. Names of streets, roads or highway that cross or border the site.

Please note that the drawings do not need to be drawn to scale. Plot plans are required for all projects.

(B) 1. Describe the relationship of the site to public transportation routes, if any, and to any highway or major road developments in the area. Describe the accessibility of the proposed site to patients/clients. ***(Not applicable to home health or hospice agency applications)***

IV. Attach a floor plan drawing for the facility which includes legible labeling of patient care rooms (noting private or semi-private), ancillary areas, equipment areas, etc. on an 8 1/2" x 11" sheet of white paper. ***(Not applicable to home health or hospice agency applications)***

NOTE: ***DO NOT SUBMIT BLUEPRINTS***. Simple line drawings should be submitted and need not be drawn to scale.

V. For a Home Health Agency or Hospice, identify:

1. Existing service area by County;
2. Proposed service area by County;
3. A parent or primary service provider;

4. Existing branches; and
5. Proposed branches.

SECTION C: GENERAL CRITERIA FOR CERTIFICATE OF NEED

In accordance with Tennessee Code Annotated § 68-11-1609(b), "no Certificate of Need shall be granted unless the action proposed in the application for such Certificate is necessary to provide needed health care in the area to be served, can be economically accomplished and maintained, and will contribute to the orderly development of health care." The three (3) criteria are further defined in Agency Rule 0720-4-.01. Further standards for guidance are provided in the state health plan ~~(Guidelines for Growth),~~ developed pursuant to Tennessee Code Annotated §68-11-1625.

The following questions are listed according to the three (3) criteria: (I) Need, (II) Economic Feasibility, and (III) Contribution to the Orderly Development of Health Care. Please respond to each question and provide underlying assumptions, data sources, and methodologies when appropriate. *Please type each question and its response on an 8 1/2" x 11" white paper*. All exhibits and tables must be attached to the end of the application in correct sequence identifying the question(s) to which they refer. If a question does not apply to your project, indicate "Not Applicable (NA)."

QUESTIONS

NEED

1. Describe the relationship of this proposal toward the implementation of the State Health Plan and Tennessee's Health: Guidelines for Growth, if applicable.

   a. Please discuss how the proposed project will relate to the 5 Principles for Achieving Better Health found in the State Health Plan. Please list each principle and follow it with a response.

   b. Please provide a response to each criterion and standard in Certificate of Need Categories that are applicable to the proposed project. Do not provide responses to General Criteria and Standards (pages 6-9 of the Guidelines for Growth) here.

   c. Applications that include a Change of Site for a proposed new health care institution (one having an outstanding and unimplemented CON), provide a response to General Criterion and Standards (4)(a-c) of the Guidelines for Growth.

2. Describe the relationship of this project to the applicant facility's long-range development plans, if any.

3. Identify the proposed service area and justify the reasonableness of that proposed area. Submit a county level map including the State of Tennessee clearly marked to reflect the service area. **Please submit the map on 8 1/2" x 11" sheet of white paper marked only with ink detectable by a standard photocopier (i.e., no highlighters, pencils, etc.).**

4. A. 1). Describe the demographics of the population to be served by this proposal.

   2) Using population data from the Department of Health, enrollee data from the Bureau of TennCare, and demographic information from the US Census Bureau,

please complete the following table and include data for each county in your proposed service area:

Demographic Variable/Geographic Area	County A	County B, etc.	Service Area Total	State of TN Total
Total Population-Current Year				
Total Population-Projected Year				
Total Population-% change				
*Target Population-Current Year				
*Target Population-Projected Year				
Target Population-% change				
Target Population-Projected Year as % of Total				
Median Age				
Median Household Income				
TennCare Enrollees				
TennCare Enrollees as % of Total				
Persons Below Poverty Level				
Persons Below Poverty Level as % of Total				

**Target Population is population that project will primarily serve. For example, nursing home, home health agency, hospice agency projects typically primarily serve the Age 65+ population; projects for the discontinuance of OB services would mainly affect Females Age 15-44; projects for child and adolescent psychiatric services will serve the Population Ages 0-19. For projects not having a specific target population use the Age 65+ population for the target population variable.*

B. Describe the special needs of the service area population, including health disparities, the accessibility to consumers, particularly the elderly, women, racial and ethnic minorities, and low-income groups. Document how the business plans of the facility will take into consideration the special needs of the service area population.

5. Describe the existing or certified services, including approved but unimplemented CONs, of similar institutions in the service area. Include utilization and/or occupancy trends for each of the most recent three years of data available for this type of project. Be certain to list each institution and its utilization and/or occupancy individually. Inpatient bed projects must include the following data: admissions or discharges, patient days, average length of stay, and occupancy. Other projects should use the most appropriate measures, e.g., cases, procedures, visits, admissions, etc. Projects including surgery should report the number of cases and the average number of procedures per case.

6. Provide applicable utilization and/or occupancy statistics for your institution for each of the past three (3) years and the projected annual utilization ~~for each of~~ through the two (2) years following completion of the project. Additionally, provide the details regarding the methodology used to project utilization. The methodology **must include** detailed calculations or documentation from referral sources, and identification of all assumptions.

ECONOMIC FEASIBILITY

1. Provide the cost of the project by completing the Project Costs Chart on the following page. Justify the cost of the project.

    - All projects should have a project cost of at least $3,000 on Line F. (Minimum CON Filing Fee). CON filing fee should be calculated from Line D. (See Application Instructions for Filing Fee)
    - The cost of any lease (building, land, and/or equipment) should be based on fair market value or the total amount of the lease payments over the initial term of the lease, whichever is greater. Note: This applies to all equipment leases including by procedure or "per click" arrangements. The methodology used to determine the total lease cost for a "per click" arrangement must include, at a minimum, the projected procedures, the "per click" rate and the term of the lease.
    - The cost for fixed and moveable equipment includes, but is not necessarily limited to, maintenance agreements covering the expected useful life of the equipment; federal, state, and local taxes and other government assessments; and installation charges, excluding capital expenditures for physical plant renovation or in-wall shielding, which should be included under construction costs or incorporated in a facility lease.
    - For projects that include new construction, modification, and/or renovation; **documentation must be** provided from a ~~contractor and/or architect~~ licensed architect or construction professional that support the estimated construction costs. Please provide a letter that includes:

        1) a general description of the project,
        2) estimate of the cost to construct the project to provide a physical environment, according to applicable federal, state and local construction codes, standards, specifications, and requirements and
        3) attesting that the physical environment will conform to applicable federal standards, manufacturer's specifications and licensing agencies' requirements including the most recent AIA Guidelines for Design and Construction of Hospital and Health Care Facilities

PROJECT COSTS CHART

A. Construction and equipment acquired by purchase:

1. Architectural and Engineering Fees _____
2. Legal, Administrative (Excluding CON Filing Fee), Consultant Fees _____
3. Acquisition of Site _____
4. Preparation of Site _____
5. Construction Costs _____
6. Contingency Fund _____
7. Fixed Equipment (Not included in Construction Contract) _____
8. Moveable Equipment (List all equipment over $50,000) _____
9. Other (Specify) _____ _____

B. Acquisition by gift, donation, or lease:

1. Facility (inclusive of building and land) _____
2. Building only _____
3. Land only _____
4. Equipment (Specify)_____ _____
5. Other (Specify) _____ _____

C. Financing Costs and Fees:

1. Interim Financing _____
2. Underwriting Costs _____
3. Reserve for One Year's Debt Service _____
4. Other (Specify) _____ _____

D. Estimated Project Cost (A+B+C) _____

E. CON Filing Fee _____

F. Total Estimated Project Cost (D+E) **TOTAL** _____

2. Identify the funding sources for this project.

   Please check the applicable item(s) below and briefly summarize how the project will be financed. ***(Documentation for the type of funding MUST be inserted at the end of the application, in the correct alpha/numeric order and identified as Attachment C, Economic Feasibility-2.)***

__ A. Commercial loan--Letter from lending institution or guarantor stating favorable initial contact, proposed loan amount, expected interest rates, anticipated term of the loan, and any restrictions or conditions;

__ B. Tax-exempt bonds--Copy of preliminary resolution or a letter from the issuing authority stating favorable initial contact and a conditional agreement from an underwriter or investment banker to proceed with the issuance;

__ C. General obligation bonds—Copy of resolution from issuing authority or minutes from the appropriate meeting.

__ D. Grants--Notification of intent form for grant application or notice of grant award; or

__ E. Cash Reserves--Appropriate documentation from Chief Financial Officer.

__ F. Other—Identify and document funding from all other sources.

3. Discuss and document the reasonableness of the proposed project costs. If applicable, compare the cost per square foot of construction to similar projects recently approved by the Health Services and Development Agency.
4. Complete Historical and Projected Data Charts on the following two pages--***Do not modify the Charts provided or submit Chart substitutions!*** Historical Data Chart represents revenue and expense information for the last *three (3)* years for which complete data is available for the institution. Projected Data Chart requests information for the two (2) years following the completion of this proposal. Projected Data Chart should reflect revenue and expense projections for the ***Proposal Only*** (*i.e.*, if the application is for additional beds, include anticipated revenue from the proposed beds only, not from all beds in the facility).

   Note that "Management Fees to Affiliates" should include management fees paid by agreement to the parent company, another subsidiary of the parent company, or a third party with common ownership as the applicant entity. "Management Fees to Non-Affiliates" should also include any management fees paid by agreement to third party entities not having common ownership with the applicant. Management fees should not include expense allocations for support services, e.g., finance, human resources, information technology, legal, managed care, planning marketing, quality assurance, etc. that have been consolidated/centralized for the subsidiaries of a parent company.
5. Please identify the project's average gross charge, average deduction from operating revenue, and average net charge.

HISTORICAL DATA CHART

Give information for the last *three (3)* years for which complete data are available for the facility or agency. The fiscal year begins in _____ (Month).

		Year____	**Year___**	***Year_____***
A.	Utilization Data (Specify unit of measure)	_____	_____	_____
B.	Revenue from Services to Patients			
1.	Inpatient Services	$_____	$_____	$_____
2.	Outpatient Services	_____	_____	_____
3.	Emergency Services	_____	_____	_____
4.	Other Operating Revenue (Specify)_____	_____	_____	_____
	Gross Operating Revenue	**$_____**	**$_____**	**$_____**
C.	Deductions from Gross Operating Revenue			
1.	Contractual Adjustments	$_____	$_____	$_____
2.	Provision for Charity Care	_____	_____	_____
3.	Provisions for Bad Debt	_____	_____	_____
	Total Deductions	**$_____**	**$_____**	**$_____**
NET OPERATING REVENUE		**$_____**	**$_____**	**$_____**
D.	Operating Expenses			
1.	Salaries and Wages	$_____	$_____	$_____
2.	Physician's Salaries and Wages	_____	_____	_____
3.	Supplies	_____	_____	_____
4.	Taxes	_____	_____	_____
5.	Depreciation	_____	_____	_____
6.	Rent	_____	_____	_____
7.	Interest, other than Capital	_____	_____	_____
8.	Management Fees:			
a.	Fees to Affiliates	_____	_____	_____
b.	Fees to Non-Affiliates	_____	_____	_____
9.	Other Expenses – Specify on Page 23	_____	_____	_____
	Total Operating Expenses	**$_____**	**$_____**	**$_____**
E.	Other Revenue (Expenses) – Net (Specify)_____	$_____	$_____	$_____
NET OPERATING INCOME (LOSS)		**$_____**	**$_____**	$_____
F.	Capital Expenditures			
1.	Retirement of Principal	$_____	$_____	$_____
2.	Interest	_____	_____	_____
	Total Capital Expenditures	**$_____**	**$_____**	$_____
NET OPERATING INCOME (LOSS) LESS CAPITAL EXPENDITURES		**$_____**	**$_____**	**$_____**

PROJECTED DATA CHART

Give information for the two (2) years following the completion of this proposal. The fiscal year begins in _____ (Month).

		Year_____	Year_____
A.	Utilization Data (Specify unit of measure)	_____	_____
B.	Revenue from Services to Patients		
	1. Inpatient Services	$_____	$_____
	2. Outpatient Services	_____	_____
	3. Emergency Services	_____	_____
	4. Other Operating Revenue (Specify)_____	_____	_____
	Gross Operating Revenue	**$_____**	**$_____**
C.	Deductions from Gross Operating Revenue		
	1. Contractual Adjustments	$_____	$_____
	2. Provision for Charity Care	_____	_____
	3. Provisions for Bad Debt	_____	_____
	Total Deductions	**$_____**	**$_____**
NET OPERATING REVENUE		**$_____**	**$_____**
D.	Operating Expenses		
	1. Salaries and Wages	$_____	$_____
	2. Physician's Salaries and Wages	_____	_____
	3. Supplies	_____	_____
	4. Taxes	_____	_____
	5. Depreciation	_____	_____
	6. Rent	_____	_____
	7. Interest, other than Capital	_____	_____
	8. Management Fees:		
	a. Fees to Affiliates	_____	_____
	b. Fees to Non-Affiliates	_____	_____
	9. Other Expenses – Specify on Page 23	_____	_____
	Total Operating Expenses	**$_____**	**$_____**
E.	Other Revenue (Expenses) -- Net (Specify)_____	$_____	$_____
NET OPERATING INCOME (LOSS)		**$_____**	**$_____**
F.	Capital Expenditures		
	1. Retirement of Principal	$_____	$_____
	2. Interest	_____	_____
	Total Capital Expenditures	**$_____**	**$_____**
NET OPERATING INCOME (LOSS) LESS CAPITAL EXPENDITURES		**$_____**	**$_____**

HISTORICAL DATA CHART-OTHER EXPENSES

OTHER EXPENSES CATEGORIES	Year____	Year___	*Year*_____
1.	$_____	$_____	*$*_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____
6.	_____	_____	_____
7.	_____	_____	_____
Total Other Expenses	$_____	$_____	$_____

PROJECTED DATA CHART-OTHER EXPENSES

OTHER EXPENSES CATEGORIES	Year____	Year___
1.	$_____	$_____
2.	_____	_____
3.	_____	_____
4.	_____	_____
5.	_____	_____
6.	_____	_____
7.	_____	_____
Total Other Expenses	$_____	$_____

6. A. Please provide the current and proposed charge schedules for the proposal. Discuss any adjustment to current charges that will result from the implementation of the proposal. Additionally, describe the anticipated revenue from the proposed project and the impact on existing patient charges.

   B. Compare the proposed charges to those of similar facilities in the service area/adjoining service areas, or to proposed charges of projects recently approved by the Health Services and Development Agency. If applicable, compare the proposed charges of the project to the current Medicare allowable fee schedule by common procedure terminology (CPT) code(s).

7. Discuss how projected utilization rates will be sufficient to maintain cost-effectiveness; how financial viability will be ensured within two years; and demonstrate the availability of sufficient cash flow until financial viability is achieved.

8. Discuss the project's participation in state and federal revenue programs including a description of the extent to which Medicare, TennCare/Medicaid, and medically indigent patients will be served by the project. In addition, report the estimated dollar amount of revenue and percentage of total project revenue anticipated from each of TennCare, Medicare, or other state and federal sources for the proposal's first year of operation.

9. Provide copies of the balance sheet and income statement from the most recent reporting period of the institution and the most recent audited financial statements with accompanying notes, if applicable. For new projects, provide financial information for the corporation, partnership, or principal parties involved with the project. Copies must be inserted at the end of the application, in the correct alpha-numeric order and labeled as Attachment C, Economic Feasibility-10.

10. Describe all alternatives to this project which were considered and discuss the advantages and disadvantages of each alternative including but not limited to:

    a. A discussion regarding the availability of less costly, more effective, and/or more efficient alternative methods of providing the benefits intended by the proposal. If development of such alternatives is not practicable, the applicant should justify why not; including reasons as to why they were rejected.

    b. The applicant should document that consideration has been given to alternatives to new construction, e.g., modernization or sharing arrangements. It should be documented that superior alternatives have been implemented to the maximum extent practicable.

CONTRIBUTION TO THE ORDERLY DEVELOPMENT OF HEALTH CARE

1. List all existing health care providers (e.g., hospitals, nursing homes, home care organizations, etc.), managed care organizations, alliances, and/or networks with which the applicant currently has or plans to have contractual and/or working relationships, e.g., transfer agreements, contractual agreements for health services.

2. Describe the positive and/or negative effects of the proposal on the health care system. Please be sure to discuss any instances of duplication or competition arising from your proposal including a description of the effect the proposal will have on the utilization rates of existing providers in the service area of the project.

3. Provide the current and/or anticipated staffing pattern for all employees providing patient care for the project. This can be reported using FTEs for these positions. Additionally, please compare the clinical staff salaries in the proposal to prevailing wage patterns in the service area as published by the Tennessee Department of Labor & Workforce Development and/or other documented sources.

4. Discuss the availability of and accessibility to human resources required by the proposal, including adequate professional staff, as per the Department of Health, the Department of Mental Health ~~and Developmental Disabilities~~ and Substance Abuse Services, and/or the ~~Division of Mental Retardation Services~~ Department of Intellectual and Developmental Disabilities licensing requirements.

5. Verify that the applicant has reviewed and understands all licensing certification as required by the State of Tennessee for medical/clinical staff. These include, without limitation, regulations concerning physician supervision, credentialing, admission privileges, quality assurance policies and programs, utilization review *policies and programs, record keeping, and staff education.*

6. Discuss your health care institution's participation in the training of students in the areas of medicine, nursing, social work, etc. (*e.g.,* internships, residencies, etc.).

7. (a) Please verify, as applicable, that the applicant has reviewed and understands the licensure requirements of the Department of Health, the Department of Mental Health ~~and Developmental Disabilities~~ and Substance Abuse Services the ~~Division of Mental Retardation Services~~ Department of Intellectual and Developmental Disabilities, and/or any applicable Medicare requirements.

   (b) Provide the name of the entity from which the applicant has received or will receive licensure, certification, and/or accreditation.

   Licensure:

   Accreditation:

   (c) If an existing institution, please describe the current standing with any licensing, certifying, or accrediting agency. Provide a copy of the current license of the facility.

   (d) For existing licensed providers, document that all deficiencies (if any) cited in the last licensure certification and inspection have been addressed through an approved plan of correction. Please include a copy of the most recent licensure/certification inspection with an approved plan of correction. Please also discuss what measures the applicant has or will put in place to avoid being cited for similar deficiencies in the future.

8. Document and explain any final orders or judgments entered in any state or country by a licensing agency or court against professional licenses held by the applicant or any entities or persons with more than a 5% ownership interest in the applicant. Such information is to be provided for licenses regardless of whether such license is currently held.

9. Identify and explain any final civil or criminal judgments for fraud or theft against any person or entity with more than a 5% ownership interest in the project

10. If the proposal is approved, please discuss whether the applicant will provide the Tennessee Health Services and Development Agency and/or the reviewing agency information concerning the number of patients treated, the number and type of procedures performed, and other data as required.

PROOF OF PUBLICATION

Attach the full page of the newspaper in which the notice of intent appeared with the mast and dateline intact or submit a publication affidavit from the newspaper as proof of the publication of the letter of intent.

NOTIFICATION REQUIREMENTS

(Applies only to Nonresidential Substitution-Based Treatment Centers for Opiate Addiction)

Please note that Tennessee Code Annotated 68-11-1607(c)(3) states that "…Within ten (10) days of filing an application for a nonresidential substitution-based treatment center for opiate addiction with the agency, the applicant shall send a notice to the county mayor of the county in which the facility is proposed to be located, the member of the House of Representatives and the Senator of the General Assembly representing the district in which the facility is proposed to be located, and to the mayor of the municipality, if the facility is proposed to be located within the corporate boundaries of a municipality, by certified mail, return receipt requested, informing such officials that an application for a nonresidential substitution based treatment center for opiate addiction has been filed with the agency by the applicant."

Please provide this documentation.

DEVELOPMENT SCHEDULE

Tennessee Code Annotated § 68-11-1609(c) provides that a Certificate of Need is valid for a period not to exceed three (3) years (for hospital projects) or two (2) years (for all other projects) from the date of its issuance and after such time shall expire; provided, that the Agency may, in granting the Certificate of Need, allow longer periods of validity for Certificates of Need for good cause shown. Subsequent to granting the Certificate of Need, the Agency may extend a Certificate of Need for a period upon application and good cause shown, accompanied by a non-refundable reasonable filing fee, as prescribed by rule. A Certificate of Need which has been extended shall expire at the end of the extended time period. The decision whether to grant such an extension is within the sole discretion of the Agency, and is not subject to review, reconsideration, or appeal.

1. **Please complete the Project Completion Forecast Chart on the next page. If the project will be completed in multiple phases, please identify the anticipated completion date for each phase.**
2. **If the response to the preceding question *indicates that the applicant does not anticipate completing the project within the period of validity as defined in the***

preceding paragraph, **please state below any request for an extended schedule and document the "good cause" for such an extension.**

PROJECT COMPLETION FORECAST CHART

Enter the Agency projected Initial Decision date, as published in T.C.A. § 68-11-1609(c): _____

Assuming the CON approval becomes the final agency action on that date; indicate the number of days **from the above agency decision date** to each phase of the completion forecast.

Phase	DAYS REQUIRED	Anticipated Date (MONTH/YEAR)
1. Architectural and engineering contract signed		
2. Construction documents approved by the Tennessee Department of Health		
3. Construction contract signed		
4. Building permit secured		
5. Site preparation completed		
6. Building construction commenced		
7. Construction 40% complete		
8. Construction 80% complete		
9. Construction 100% complete (approved for occupancy		
10. *Issuance of license		
11. *Initiation of service		
12. Final Architectural Certification of Payment		
13. Final Project Report Form (HF0055)		

* **For projects that do NOT involve construction or renovation: Please complete items 10 and 11 only.**

Note: If litigation occurs, the completion forecast will be adjusted at the time of the final determination to reflect the actual issue date.

AFFIDAVIT

STATE OF _____

COUNTY OF _____

_____, being first duly sworn, says that he/she is the applicant named in this application or his/her/its lawful agent, that this project will be completed in accordance with the application, that the applicant has read the directions to this application, the Rules of the Health Services and Development Agency, and T.C.A. § 68-11-1601, *et seq.*, and that the responses to this application or any other questions deemed appropriate by the Health Services and Development Agency are true and complete.

_____
SIGNATURE/TITLE

Sworn to and subscribed before me this _____ day of _____ (Month), _____ (Year) a Notary

Public in and for the County/State of _____.

_____
NOTARY PUBLIC

My commission expires _____ (Month/Day), _____ (Year).

SUPPLEMENT TO THE CERTIFICATE OF NEED APPLICATION FORM-NURSING HOME SERVICES

Please complete the following charts below pertaining to the applicant facility and all service area nursing homes:

Service Area Nursing Home Utilization-Most Recent JAR

Facility	Licensed Beds	SNF Beds-Medicare	SNF/NF Beds-Dually Certified	NF Beds-Medicaid/TennCare	Licensed Only Beds Non-Certified	SNF Medicare ADC	Medicaid/TennCare NF level 1 ADC	Medicaid/TennCare NF level 2 ADC	*SNF All other Payors* ADC	*NF All other Payors* ADC	Total ADC
TOTAL											

Applicant Facility Historical and Projected Utilization-Part 1

Year	Licensed Beds	*Medicare-certified beds	SNF Medicare ADC	Medicaid/TennCare NF level 1 ADC	Medicaid/TennCare NF level 2 ADC	SNF All other Payors ADC	*NF All other Payors* ADC	Total ADC	Licensed Occupancy %
Previous Year 2									
Previous Year 1									
Current Year									
Interim Year 1									
Interim Year 2									
Interim Year-etc.									
Project Year 1									
Project Year 2									

* Includes dually-certified beds

Applicant Facility Historical and Projected Utilization-Part 2

Variable	Previous Year 2	Previous Year 1	Current Year	Interim Year 1	Interim Year 2	Year 1 After Project	Year 2 After Project
Beds							
Patient days							
Average Daily Census							
% Occupancy							

Service Area Patient Accommodation Mix-Most Recent JAR Period

Nursing Home	Licensed Beds	Total Private Beds	Total Semi-Private Beds	Total Companion Beds	Ward Beds
Service Area Totals					
Proposed Project					

Applicant Facility-Historical and Projected Bed Mix

Current Private Beds	Current Semi-Private Beds	Total Current Beds	Proposed Private Beds	Proposed Semi-Private Beds	Proposed Total Beds	After Project-Total Private Beds	After Project-Total Semi-Private Beds	After Project-Total Beds